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SOCIAL WORKERS PERCEPTION OF FACTORS EFFECTING CLIENT'S RETURN TO SKILLED-NURSING CARE FACILITIES POST-DISCHARGE

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A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

by

Angela Bonilla

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ABSTRACT

The following study explored the factors effecting client's return to skilled nursing facilities post-discharge, from the perspective of the social workers and social services staff working within skilled nursing facilities. The significance of this research was to gain a better understanding from the individuals working closest to the problem, and to use the information gained to develop further research regarding the issue of rapid-readmission post discharge. This study was qualitative with the use of an interview guide. Audio data was collected through 9 Zoom interviews and then transcribed for content analysis. Through content analysis the researchers examined the respondent's answers looking for four common themes. Within these themes, the issue of homelessness, income, discharge location, substance abuse/mental health, the effectiveness of home health agencies, lack of family support, and the client's own self-neglect/non-compliance with treatment were amongst the most common topics to be brought up by respondents. Understanding these common themes and issues impacts both the social worker and the client, by providing an understanding of which policies and practices are successful or not successful both within skilled nursing facilities and out in the community.

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CHAPTER ONE

INTRODUCTION

Problem Formulation

Social workers have the skills to assist individuals in multiple settings, from county agencies to medical facilities. At each setting, social workers are focused on engaging and assisting specific populations, with the goal of increasing their quality of life. Within skilled nursing medical facilities social workers assist clients with resources while they are admitted, and provide resources post-discharge. Social workers are faced with providing services to a variety of patients with different medical needs as well as mental disorders.

The responsibility of coordinating discharge to a lower-level of care falls upon the social worker. As described in the NASW Standards for Social Work Services in Skilled nursing Care Facilities (2003) discharge planning is part of the social work program functions. The challenges they face in personalizing the care and interventions for each patient can become overwhelming. Social workers are required to assess the client, implement successful interventions for the client, assist with discharge planning and placement, and support clients who lack family involvement in their care during their transition back into the community. Although resources are provided to clients for community living, the rate at which client's return to skilled nursing facilities post-discharge is increasingly high. The term "revolving door" is a phenomenon used to describe

the rapid readmission of clients back to a facility, upon being recently discharged (Hamden, Newton, McCauley-Elsom and Cross, 2011).

Dictated by insurance, facilities have a maximum amount of time they can care for a patient. The California Department of Health (2016) reported, once a client's medical needs have been met and they are able to complete their activities of daily living, the patient is eligible to be discharged. The organization further explained, that the skilled nursing facilities are able to discharge residents on the basis that their health has stabilized and the client no longer requires the care provided by a skilled nursing facility

An expedited client discharge, can hinder the social worker's ability to provide a smooth and safe discharge for the client back into the community. Often clients are discharged back into the community, without the adequate amount of community resources. Padgett, Gulcur & Tsembers (2006) found that social workers expressed a lack of service integration and also a lack of resources for clients, specifically with clients diagnosed with dual diagnosis who were transitioning back into the community. In addition, many clients who are discharged from facilities end up homeless, and cycle back into the medical system in order to meet their basic human needs.

Social workers who work in skilled nursing medical facilities, are caught in the middle between adhering to the National Association of Social Workers "Code of Ethics", and having to follow facility policies. By discharging the client's too quickly, it puts social workers at risk of potentially violating the Code of Ethics

Standard 1.17 “Termination of Services”. This standard, requires social workers to make all necessary arrangements to have continuity of care for clients (National Association of Social Workers [NASW], 2017). The intent of social workers, is to provide the client with substantial resources to ensure the clients will be successfully discharged to the community without returning back into treatment.

The current “revolving door” phenomenon illustrates that there is clearly a missing piece to the practice of discharging clients from skilled nursing facilities. Mor, Intrator, Feng & Grabowski (2020) argue what use to be a convalescent nursing home for the geriatric population has now turned into a post-acute rehabilitation center where services like physical therapy, occupational therapy, speech therapy and wound treatment are rendered. Their study further explained, post-acute rehabilitation centers are now considered a stopping point where patients recover, and are no longer considered permanent placement. (Mor, Intrator, Feng & Grabowski, 2010). With this change, social workers are faced with the difficult task of referring patients for discharge who are medically stable, but may not have the adequate support needed for full community living.

Purpose of the Study

The purpose of this study is to understand the factors that contribute to the rapid readmission of clients back into skilled nursing facilities (SNF) post-discharge, from the perspective of the social workers working in skilled nursing facilities. The discharge and care received by a client while in a SNF is an

interdisciplinary approach. However, it is the social worker that is given the task of assisting clients transition back into the community by ensuring the client is referred and provided with the resources and community support needed to have a successful reentry back into the community (Social Work Service Unit-Services, 2020). Social workers discharge clients from facilities with an array of needs including medical, substance abuse, mental health, and housing insecurities. Due to various factors, clients are not always able to be successful in the community and return back to SNF for services. Rapid readmissions back into facilities puts pressure on staff, resources, and ultimately does not provide stability for the clients. In addition to the social and emotional impact, rapid readmission is financially taxing. Jenks, William and Coleman (2009) found that the cost of readmission from SNF to hospitals cost Medicare $17.4 billion dollars.

The overall research method used for this study was qualitative. The study was conducted by interviewing nine social workers currently employed in various skilled nursing facilities. The rationale for this type of research method, is to gain the perspective from the individuals working directly with this population. Social work staff were asked open-ended questions that allowed them to express what they believed to be the factors that contribute to the rapid readmission as well to voice the current barriers they are facing that may be preventing them from discharging patients without their immediate return. Having this perspective

allowed the researches to understand the problem of rapid-readmission from those that deal with it the most frequently.

Significance of the Project for Social Work Practice

At this time, there is a lack of research concerning skilled nursing care facilities and readmission rates, from the perspective of social workers. While there are many factors that contribute to the problem of high readmission rates this qualitative study explored and attempted to understand the challenges social workers are facing while working in skilled nursing facilities. This study demonstrated the exploration phase of the generalist model, by developing an understanding of the current problem, and generating information for further research in this area. This qualitative study provided information at both the micro and macro level for social workers in the field. At the micro level, social workers could evaluate their own current practices and evaluate those that are successful and those that need improvement, directly affecting the clients they work with.

At the macro level, this study provided perspective from multiple social workers, allowing the researchers to evaluate whether the current regulations governing skilled nursing facilities are contributing or hindering social workers ability to successful discharge patients back into the community. Having this information could lead to further policy advocation for social workers in the field. In addition, this research hoped to impact the patients and clients of skilled

nursing facilities by understanding the factors that impact their discharge while in a SNF, and understanding the factors that are affecting them once in the community. Through this study the research question that was explored was: What do social workers working in skilled nursing medical care facilities perceive as the factors that contribute to increased return rates for clients discharged from facilities.

CHAPTER TWO

LITERATURE REVIEW

Introduction

A client's discharge into the community, without immediate return is the goal of social workers working within skilled nursing care facilities. The following chapter will provide information regarding the social workers role within a nursing home facility, current research on readmission rates, and discussion of possible factors that lead to readmission. This chapter will also demonstrate how Person in Environment Theory and Social Constructivism Paradigm will help guide this research project.

The Role of a Social Worker in a Skilled Nursing Care Facility

According to federal regulation, skilled nursing care facilities are required to have one full-time social services staff member if their facility has more than 100 patients (Bern-Klug, Kramer, Sharr & Cruz, 2010). Federal regulations also do not dictate whether the individual working as a skilled nursing care facility social worker is degreed or not (Bern-Klug, Kramer, Chan, Kane, Dorfman & Saunders, 2009). Social Services staff are required to have received a certificate and training in social services, whereas a social worker has received their bachelor's or master's degree in social work. The duties and role of both titles are the same and include but are not limited to; advocating for the resident while in the care of the facility, assisting the client in adjusting to the new facility,

providing emotional support, communicating with family and support systems, referring the client to the appropriate services, and eventually beginning the process of assisting the client with discharge planning (Social Work Service Unit-Services, 2020).

Social Workers and social services staff who work in skilled nursing care facility are part of an interdisciplinary team composed of doctors, nurses, registered-dieticians, and other professionals. Research conducted by Vongxaiburana, Thomas, Fraham and Hyer (2011), argued that social workers are an integral part of the skilled nursing interdisciplinary team. Their research concluded that skilled nursing care facilities with more than the federal requirement of social workers and social services staff, had lower resident assessment deficiency scores during their state audit survey, concluding that social workers contribute to better interdisciplinary assessment and care planning for patients.

Social workers begin to assess the client upon admission into the skilled nursing facility by completing a biopsychosocial assessment of the resident. While the client is receiving skilled services and medically related services, the social worker is working collaboratively with the interdisciplinary team; these include other professionals in the skilled nursing facility as well as outside agencies (NASW, 2003, p. 20). Communication is important to determine the needs of the client to begin planning a proper and safe discharge plan. Social workers are also responsible for building positive relationships with community

resources and linking clients to those resources once the client is returning and transitioning back into the community. As described in the NASW Standards for Social Work Services in Skilled nursing Care Facilities (2003) social workers connect and secure an array of community-based resources for the client's they serve.

Although social workers are trained and capable of handling multiple populations, many skilled nursing social workers are overwhelmed and faced with high staff to patient ratios in their facilities. Bern-Klug, Kramer, Sharr and Cruz (2010) surveyed 1,071 social services staff from skilled nursing care facilities across the United States, their research found that three-fourths of participants believed that one social services employee should handle a maximum of 60 skilled nursing patients. In addition, over half of participants believed that for patients that needed more extensive medical treatment, the ratio should be 1 to 20 patients.

Readmission Research

Much of the research regarding readmission rates has examined rates from skilled nursing skilled nursing facilities back into higher level hospital care. This transfer from skilled nursing facility to a hospital has been a high public policy concern, due to the multi-billion dollars of Medicare used for these readmissions (Jencks, Williams & Coleman, 2009). Skilled nursing care facilities are under pressure from hospitals when it comes to readmissions of medicare patients, as hospitals are receiving penalties for high rates of readmissions from

the Centers of Medicare and Medicaid services (Rau, 2019). Nursing homes are encouraged to decrease the number of emergency visits, if medical needs can be met at the skilled nursing facility, to avoid a readmission (Ouslander, Naharci, Engstrom, Shutes, Wolf, Rojido, & Newman, 2016). Zuckerman, Sheingold, Orav, Ruhter, and Epstein (2016), saw a decline in readmission rates, as a result of the Affordable Care Act penalizing hospitals for readmitting patients from skilled nursing facilities back to the hospital 30-days post hospital discharge. In addition, nursing homes are provided with additional incentives when reducing the number of readmissions to the hospitals (Ouslander, et al., 2016).

The geriatric population is the primary population served by skilled nursing care facilities. The National Center for Health Statistics (2019) conducted for 2015-2016, determined that 83.5% of nursing home clients were 65 years and older. Much of the research conducted has been from a medical and public policy point of view regarding the readmission of the geriatric population. However, little to no research has been conducted from the perspective of social workers who assist with discharge, and what factors they believe contribute to the readmissions of their clients.

Factors Affecting Readmission

Multiple factors are present and have been researched regarding the factors affecting readmission to skilled nursing care facilities from the public policy and medical point of view. Provided is not an exhaustive list of factors affecting readmission. The factors that will be discussed include lack of service

from community providers, lack of important medical information from the hospital at the time of admission at a skilled nursing care facility, and patients discharging against medical advice (AMA).

Lack of Service from Community Providers

The first factor that can affect readmission is the lack of services from community providers. Community providers include home health agencies that are assigned to follow the client after discharge. The home health agencies are responsible for coordinating care at home for the client, with the help of the home health staff and doctors. They assist the client on healthy eating habits and observing their overall health condition (Medicare.gov: the official U.S. Government Site For Medicare, 2016). Community providers are a vital part of the clients transition back into the community. Home Health agencies are in place to assist patients in transitioning back into the community and helping with maintaining their independence while promoting client safety and quality care (Ellenbecker, Samia, Cushman & Alster, 2008). Depending on the level of assistance a client needs when returning home, the community-based provider is responsible for the delivery of these services. Without proper follow up and continuity of care the risks of a client returning to the hospital are significant. Community service providers hold a very important role, it is because of their home services that the client can continue to remain at home and maintain their level of independence.

Chapin, Rosemary Kennedy (2014) conducted a study with hospital discharge planners and found that the discharge planners expressed a sense of responsibility to make the discharge as safe as possible. Although they have the best intentions, the discharge coordinator is unable to make referrals or initiate discharge plans until the physician has entered the discharge order. Once the order has been entered, the social worker is expected to discharge the client and make the appropriate referrals with the expectation that those referrals will be following the client right after discharge. Time barriers described by the discharge coordinators pose a major problem when it comes to the continuity of care. In the same study conducted by Chapin, Rosemary & Kennedy (2014), found the trend of community service providers stating notification for discharge was given the day of discharge or the day after the discharge.

Lack of Pertinent Medical Information Upon Admission

The second factor to contribute to the readmissions, are the lack of critical medical information provided to skilled nursing care facilities at the time of transferring a client to a skilled nursing care facility (Ouslander, et al., 2016). The skilled nursing care staff and physician relies on the hospital to provide the necessary medical information and documentation. The information is important in order for proper medical care at the skilled nursing medical facility to be initiated and continued. If the documentation is incomplete, then the client can have complications during the process of their recovery. Without the full medical information, the physician and the skilled nursing staff are unable to determine

the best intervention for the client, ultimately deciding to send the client back to the hospital for re-evaluation. In addition, lack of documentation from the nursing home to the hospital has been reported to be a problem as well. Jones, Dqyer, White & Firman (1997) found that a common mistake made by nursing homes while transferring a patient to the hospital included lack of documentation and information pertaining the patient's current health and status was not included when the client was sent to the hospital, along with the physician not being aware the patient was going to hospital.

Client's Discharged Against Medical Advice

A third factor that can affect the rapid readmission rates, unfortunately unavoidable at times are patients that leave against medical advice (AMA). According to Garland et al., (2013) discharging from a facility increased the risk of readmission to a facility and possible death. Patients that have the capacity to understand and make decisions are permitted to leave the hospital or skilled nursing care facility against the physicians' authorization. Glasgow, Vaughn-Sarrazin, & Kaboli (2010) conducted a study in several Veterans Affairs hospitals and found, when patients left against medical advice they had higher 30-day readmission rates as well as a higher 30-day mortality rates compared to other patients.

Theories Guiding Conceptualization

The two theories used to conceptualize the research in this study are Persons in Environment Theory (PIE) and Social Constructivism. Persons in

environment theory guides this research due to its understanding that the environment shapes an individual. The purpose of this research was to understand what factors assist or deter clients when discharged from skilled nursing care facilities, from the perspective of social workers and social services staff in skilled nursing facilities. The research was guided and understood through the lens of social workers and the impact they have on the client's they serve. The skills or lack of skills provided to the patient by the skilled nursing facility social worker will have an impact on the client's ability to be successful in the community. Research conducted by Mills, Snow, Wilson, Naik & Kunik (2013), created a tool-kit framework that pulls from PIE theory. The focus of their conceptual tool kit, is based on three important tenets. The first being to have a thorough understanding of the client's competencies, the second is to develop client centered goals based on their available competences, and third having structured care planning that supports their goals. The tenets of this tool-kit framework put the responsibility on the skilled nursing staff to understand a client's abilities and capitalize on those in order for them to be successful.

Social Constructivism Theory also guided this research, the theory emphasizes that an individual or group has formed a version of reality that has been shaped by their experience and their knowledge (Kim, 2001). Social Constructivism will help the researcher in understanding the common barriers and factors social workers in skilled nursing care facilities experience. The study will discuss the social workers belief on what factors contribute to the rapid

readmission to skilled nursing care facilities based and experiences while coordinating discharges.

Summary

Social workers are integral aspects of the interdisciplinary team of skilled nursing facilities, faced with utilizing the resources available to discharge clients effectively. Governed by state regulations, many social workers are forced to work with high staff to patient ratios within skilled nursing facilities. Although, there are many factors that can affect a client to be readmitted to a facility, the research that is currently available understands these factors from the perspective of the medical, policy, and economic standpoint. This research study utilized Persons in Environment Theory and Social Constructivism to guide and understand from the social worker point of view the factors that cause readmission to SNF post-discharge.

CHAPTER THREE

METHODS

Introduction

The purpose of this study is to understand the factors that contribute to the rapid readmission of clients back into skilled nursing facilities post-discharge from the perspective of the social workers and social services staff working in skilled nursing facilities. This chapter will provide the parameters and structure of the study. This chapter will provide a discussion of the study design, sampling techniques, data collection and instruments, procedures, protection of human subjects, and data analysis.

Study Design

The purpose of this study was to discover what social workers working in a skilled nursing care facility believe to be the factors contributing to the rapid return of patient's post-discharge. Much of the research on rapid-readmission is from the perspective of hospitals and insurance companies, and little to no research has been done from the perspective of social workers. Due to the lack of research available, this was an exploratory study. Through the exploration of this issue, the goal for the researchers will be to uncover and understand the current themes and issues faced by social workers working in skilled nursing facilities.

Due to the investigative nature of this research, a qualitative research methodology was utilized in order to gain a thorough perspective about the issues faced by the social services staff in skilled nursing facilities. Participants were interviewed using open-ended questions.

A strength of this qualitative interview-based study was the ability for the researchers to explore the problem in-depth. Asking the participants open-ended questions, created a space for the social workers to explain their experience with the problem and elaborate on their individual experience. Gaining the perspective of each individual social worker was essential as it allowed the researchers to verify themes and commonalities amongst the social workers, and allows for new themes and issues to present themselves. In addition, the interviews allowed the researchers to guide the questions being asked of the participant and make observations on nonverbal responses and document these observations.

The limitations of this study include, the time-consuming nature of the study and a small sample size. Having a small sample size did not allow for generalizability to the general public about the issue. Another limitation of in-depth open-ended questions is the possibility of making the participants uncomfortable, and their lack of disclosure regarding the issues. Some participants may of felt uncomfortable that they were disclosing too much information and putting their agency in a negative light, or felt they were non-supportive of their role in the agency.

Sampling

Participants were recruited through the use of the non-probability sampling technique of snowball sampling. Both researchers utilized their own personal contacts from various skilled nursing facilities in San Bernardino, Riverside and Los Angeles County to recruit approximately seven to ten social workers and social worker staff to take part in the study. The only selection criteria for the study was that participants had to have worked in a skilled nursing care facility for at least one year prior to participating and have or have had the title of social worker, social services personnel, or discharge coordinator. Utilizing this selection criteria, ensured that the participants had the knowledge and experience of discharging patients into the community, as well as have dealt with the readmissions of client's post-discharge.

Data Collection and Instruments

Due to the exploratory nature of this study, there is was not a comprehensive interview guide currently available. In order to gather data, the researchers created their own interview guide. The interview guide measured data both qualitatively and quantitatively. The quantitative section was brief and was solely utilized to measure demographics such as gender, age ethnicity, education level, current title, and what county the respondent's facility resided in. The qualitative section was nine open ended questions. The interview guide was composed of questions guided from the literature as well as questions the

researchers created in order to understand the overall experience and perspective of the participants working with rapid-readmission clients.

In order for the interview guide to be valid multiple steps were taken. The first step was to test the interview guide for face validity. To test for face validity the interview guide was given to the research advisor to examine the guide for its ability to ask questions that address the intended research question. The second step was be to test the content validity of the interview guide. The researchers utilized their research advisor to provide an in-depth examination of the guide, to provide feedback and commentary on the content of the questions. All feedback and commentary received by the research advisor was utilized to rewrite the questions. Having the researcher advisor provided face and content validity ensured that the questions being asked of the participants were written properly and elicited the most open-ended thoughtful responses from participants.

Creating an interview guide as the data collection tool for this study had both strengths and weaknesses. The strength of this tool, was that it allowed freedom to the researchers to ask specific questions to this niche population. However, having complete control of the questions does lead to limitations, as it can create various systematic errors including bias from both the researchers and participants. In order to control for the researcher's bias, the researchers had their interview guide validated by their faculty advisor in order to ensure the questions that were being asked did not have language that would push respondents to answer in any particular way.

Procedures

Participants were recruited by the researchers initially by phone then followed by an email that included information regarding the interview. The email included: the purpose and rationale behind their participation in this study, the length of time the interview would take, and the contact information of the researchers. Participants were requested to respond via email their availability and preferred time and day to be interviewed. The participants were not expected to participate in the study during work hours. Due to COVID-19 precautions all interviews were conducted virtually via Zoom in a semi-private setting where the participant felt comfortable.

On the day of the scheduled interview, only one researcher conducted the interview with the participant. The researchers provided the participant the consent form via email before the interview, and asked for it to be emailed back before the scheduled meeting. Due to the interview taking place on Zoom participants were notified and consented to the interview being recorded for transcription purposes. The researcher also reiterated to the participant that at any time they could stop the interview and conclude the process as their participation was completely voluntary. The researcher began with the demographic questions and then proceeded to the interview guide. Upon completion of the interview the researcher thanked the participant for their participation and asked if they have any final thoughts on the study.

Protections of Human Subjects

Participants involved in this study were made aware that all information that was obtained during the interview process would be kept confidential. Participants were informed that their names would not be used in the study. The researchers identified the interview only by the date it was conducted. In addition, no information other than the county in which the facility resides will be asked about the participants current facility. This was to ensure that the participant felt comfortable disclosing without fear of repercussions from their employer. Each participant was provided an informed consent and consent for audio/video recording at the beginning of the interview. Each interview was done separately to ensure privacy and confidentiality amongst participants. All audio/video recordings were stored in a password protected file on both researchers' computers. Upon completion of the study, all audio/video recording and documentation will be destroyed.

Data Analysis

To complete the analysis of this qualitative data, the researchers utilized a multiple step approach to transform the words of the interview into tangible measurable data. The first step was to transcribe the audio verbatim from each interview. In each transcription the researchers also included any non-verbal cues noted within the interview. The second step was to complete a thorough content analysis of each transcription. During the content analysis, the transcribed interviews were examined for common themes, words, and subjects.

A count was taken on the amount of times these common phrases, words, or subjects came up within each interview. A table of the results was created to list the themes and ideas that were mentioned. The researchers then compared the themes across each of the interviews to access for commonalities or differences. The demographic context of each interview was used to understand if there were any commonalities or differences of themes reported based off the respondents age, title, education level, or county in which the facility resided in.

Summary

Through an exploratory research design the study attempted to understand the factors of readmission post-discharge from the perspective of social workers working in skilled-nursing facilities. Participants were solicited through a snowball sampling technique and data was gathered through virtual Zoom interviews. Throughout the entire process both researchers made every effort to keep the participants information safe and secure. The data provided in the interviews was analyzed for common themes and subjects for the researchers to verify if there are similarities or differences in the perceived factors of readmissions from social work staff.

CHAPTER FOUR

RESULTS

Findings

This chapter presents the findings of this study, in the format of demographics and five themes. These themes encapsulate the ideas that were expressed by participants during their interviews. The themes include: Persons, Places, Things/Artifacts, and Ideas. Each of these themes help to understand the causes of Rapid Readmission Post-Discharge.

Demographics

The interviews were conducted with social workers, social services directors, social services designees, and discharge coordinators. Table 1 shows the demographics of the participants. The participants ages range from 26-35, 36-45 years old and older 56 and above. The participants education background included master's, bachelor's, associate degree, and some college. The counties where the participants work include San Bernardino County, Riverside County and Los Angeles County. The ethnicities of the participants included White, Hispanic/Latino and Black/African American. The demographics did not include experience in this area of social work due to the participants meeting the requirement of at least one year of experience working in the field. Table 1 presents the demographic information of the participants, breaking it down by

gender, age, ethnicity, education level, title, and county in which the facility resides.

Table 1. Demographics of Research Participants

Gender	
Female	8
Male	1
Age Range	
26-35	5
36-45	2
56+	2
Ethnicity	
White	2
Hispanic/Latino	5
Black/African American	2
Education level	
Master	2
Bachelor	3
Associate	1
Some College	3
Title	
Social Worker	3
Social Services Director	4
Social Services Designee	1
Discharge Coordinator	1
County	
San Bernardino	5
Riverside	1
Los Angeles	3

Four Themes

Tables 2-5 represents the four different themes that were identified after meticulously reviewing, analyzing, and interpreting the data. The themes that were identified were Person, Places, Thing/Artifact, and ideas. Table 2 provides

a list of all the various items mentioned by participants that fell under the theme of people.

Table 2. Theme: People

- Physician/Doctor
- Home Health Agencies
- Meals on Wheels
- In Home Support Services
- Caretaker/Caregiver
- Family
- Younger Clients
- Homeless
- Home health nurse
- Physical Therapy
- DME Company
- Convalescent Aid Society
- TAD Office
- Set Free Church
- Salvation Army
- Case Management

Table 3 provides a list of the various places the client can be discharged to or interact with while in the community, as mentioned by the participants during the interviews.

Table 3. Theme: Places

- Shelter
- Room & Board
- Board & Care

- Hospital
- Pharmacy
- Nursing Home to Home
- Nursing Home
- Society
- Independent Living/Sober Living
- Home Health Services
- Day Center
- Emergency Room
- Adult Daycare Programs
- Rehab
- streets

Table 4 provides a list of the various tangible Things/Artifacts mentioned by participants.

Table 4. Theme: Things/Artifact

- Insurance
- Walker, Wheelchair
- Supplies
- DME Equipment
- Transportation
- Alcohol & Drug Abuse
- Resources for Programs
- Housing
- Income/Lack of income
- Addiction
- Social Security Benefits
- Money
- Wheelchair Accessible
- IHSS
- Public transportation
- Healthnet
- Access or Get About
- AA meetings

- Drug Problem
- Medication
- Support System
- Infections
- Living Alone
- Repeated Falls
- Not having proper care
- Appointments
- Managing their medication
- Dementia
- Money
- Biopsychosocial assessment
- Caregiving resources
- Food stamps
- Advanced Directives
- In-patient/Outpatient substance abuse resources
- Short-term Social Security
- Prescription Assistance Programs
- Schizophrenic
- Methamphetamines
- No Cell Phone
- The Senior Information Hotline
- Primary Care Physician Follow-up Appointment

Table 5 mentions various ideas related to rapid-readmission post-discharge, as mentioned by the participants. The ideas are listed as direct quotes, in order to capture the participants thoughts accurately from the transcription.

Table 5. Theme: Ideas

- Non-compliant/Self-neglect
- California's cost of living
- (Personal Communication, Participant 3, September 26, 2020)
  "I feel like the number one thing that this kind of resident's need is somebody there pushing them to follow through, to continue care."
    - "Residents that are returning they just do the minimum"

- (Personal Communication, Participant 3, September 26, 2020)
  “It’s been my experience that home health don’t spend a lot of time like they should”

- (Personal Communication, Participant 3, September 26, 2020)
  “It’s a vicious cycle, they normally go to independent living and board and care and the reason why they go there is because it’s the only thing they can afford and so as a social worker it's challenging because you really want this individual to if I could I would discharge them to an actual rehabilitation center for their addiction or I would discharge them to like an actual license board and care or like I don’t know somewhere where they could do classes and maintain and not have to pay so much money out of their social security but because that’s the only thing they could afford and that’s the discharge process you know”.

- (Personal Communication, Participant 3, September 26, 2020)
  “Being discharged to these places they end up again in the streets and they come back to you”.

- (Personal Communication, Participant 4, September 26, 2020)
  “A strong barrier right now, finding them a safe place back in the community”.

- (Personal Communication, Participant 4, September 26, 2020)
  “If they don’t have medical, then they don’t have resources or services that they could get out there. If they have blue shield or they over qualify for medical, but I think that all seniors should have services like IHSS. When they hit a certain age”.
    - “They are only there for an hour I believe, to bathe them and but they should at least help them with other things too if they can”.

- (Personal Communication, Participant 5, September 20, 2020)
  “A lot of the barriers were if they were living independently, just not having the means to pay for additional help to provide you know ADL care at home”.

- (Personal Communication, Participant 5, September 20, 2020)
  “I think a lot of it was just either leaving before they were ready, so requesting discharge. Some would leave against medical advice, and sure enough within a week or two they would be back”.

- (Personal Communication, Participant 5, September 20, 2020)

“Family isn’t really involved more or less likely if they don’t have any family support that’s when they usually come right back”.

- (Personal Communication, Participant 6, September 25, 2020)
  “You might have behavioral issues, they can be combative, they can be aggressive, which makes it difficult for placement because facilities do not want to take that. It could be a matter too, of them not having anyone to make medical decisions for them. So, there's nobody to sign them into a facility. So then we have to look at if we have to file conservatorship for them.”
    - “Limited resources in the community or in the county”.

- (Personal Communication, Participant 6, September 25, 2020)
  “It could be mental health that they have a mental health condition that keeps bringing them to the hospital”.
    - “Substance abuse, alcoholism, overdoses, those are things that bring people in frequently because their behavior changes when they're under the influence or they medically need something as a result of their drug use or alcohol use”.
    - “Either they keep going home with family and family can't adequately handle them or they cause problems at the facility”.

- (Personal Communication, Participant 6, September 25, 2020)
  “The new homeless initiative is quite interesting. I don't know if you're familiar with it, but hospitals, we have to essentially provide them with a meal, with clothing and transportation to wherever they want to go upon discharge, essentially. So I think this is contributing to us seeing a lot more homeless individuals in the hospital because it's gone around that all the hospitals give free transportation. So unfortunately, instead of them really coming in for medical conditions, they come in frequently so they can get all those fun benefits that they can get that they're entitled to, because now it's the law that we have to provide that to them”.

- (Personal Communication, Participant 6, September 25, 2020)
  “Their mental health and their substance abuse, their behavior issues have kind of prevented them from having a big, strong support system behind them because they've kind of burned their bridges”.
    - “Specific for mental health and homeless, it's a revolving door, they're just in and they're out and there's no real long-term solution for most of them unless we get them into long term custodial placement at a skilled nursing facility, which most homeless individuals do not want, because then they lose their Social Security income and they want that money to use for whatever they want to use it on”.

- “The problem with these free programs that are easier to get into is they won't take people that are on psychotropic medications, which is a high amount of our population”.

- (Personal Communication, Participant 6, September 25, 2020) “Self-neglect is a huge issue”.

- (Personal Communication, Participant 7, September 25, 2020) “An individual who is homeless has a much more difficult time finding a facility because they don't have a plan post discharge, so facilities are reluctant to accept them”
    - “I mean, again, particularly our homeless population, they just feel hopeless and helpless. A lot of them do not believe that they are deserving of a better lifestyle”.

- (Personal Communication, Participant 8, September 27, 2020) “The lack of services that the county provides for people including the homeless, like we do not have any support for our homeless population.”

- (Personal Communication, Participant 8, September 27, 2020) “It is people with substance abuse issues or mental health issues that permanent placement doesn't work for them. So even if we get them into a room and board, if they have a substance abuse issue, they are not going to stay in that room and board for long before they're back out on the streets. And then even if we get them home, it's not that long till they burn a bridge at home, they've gotten into it with someone there or whatever, and they end up back on the streets and from the streets to the hospital, from a hospital back to us”.

- (Personal Communication, Participant 8, September 27, 2020) “Consistency from being in a skilled nursing facility and being basically catered to, you know, we are bringing you your meals, we’re doing your laundry, we're picking you up, it's time for rehab, let's go. You know, and then going home. And there is no one there to tell you what to do or when to do it or, hey, it's time to take your medication”.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter will discuss the factors within the four themes of People, Places, Things/Artifacts, and Ideas that were most mentioned by the respondents, the significance of each factor, and will provide insight into how these factors play a part in rapid readmission post-discharge. In addition, this chapter will provide the limitations of this study as well as the further implications this study can provide for social work researchers in the future.

The factors that were most prevalent from respondents regarding a client's rapid-readmission back into a skilled nursing facility include, individuals returning due to homelessness, lack of services from home health agencies, client's being discharged to room and boards, the client's mental health and substance abuse disorder, lack of family support, whether the client has adequate income, and finally the client's self-neglect/noncompliance with treatment.

Homelessness and Lack of Income

Across the nine interviews the word homeless/homelessness was mentioned 41 times. Many of the respondents believed that whether a client had stable housing and adequate income post-discharge, would impact the rate at which they returned back for services. The respondents identified that clients without stable housing had many barriers that made it difficult to be successful in

the community, and from their experience would return for services the most frequently. Respondent 6 explained from their experience those that were homeless experienced the highest readmission rate post-discharge.

> Homeless patients specifically, have a high turn around. And that's for many different reasons. It could be mental health that they have a mental health condition that keeps bringing them to the hospital (Personal Communication, Participant 6, September 25, 2020).

The rapid-readmission amongst this population was explained by respondents to be because of the various barriers these client's face both during the discharge process and while back in the community. Participant 4 explained that homelessness is a barrier that both the social worker and client face during discharge due to not being able to find them a safe place post-discharge.

> Barriers are some of them that come in with no income and that are homeless. Big homeless population that's a strong barrier right now, finding them a safe place back in the community. (Personal Communication, Participant 4, September 26, 2020)

Information was also given by respondents regarding the inability for a social worker to find placement for those that are homeless due to the client not having a solid plan post-discharge. In addition, the respondents provided information that another barrier they see in the homeless population is feelings of unworthiness and losing hope for the future. Participants 7 gave the following information.

> An individual who is homeless has a much more difficult time finding a facility because they don't have a plan post discharge, so facilities are reluctant to accept them. I mean, again, particularly our homeless population, they just feel hopeless and helpless. A lot of them do not believe that they are deserving of a better lifestyle. (Personal Communication, Participant 7, September 25, 2020)

Another factor that was given as a contribution to the readmission post discharge is the client having a lack of income. Clients who received social security benefits do not receive enough to allow them to rent in a license/regulated facility with more services. A Genworth cost of care survey conducted in August 2020 revealed the average cost of assisted living in California was $4,500 a month. (Genworth,2020) Clients receiving social security disability benefits and supplemental income did not make enough to pay for an assisted living or board and care, decreasing their chances of receiving care at a lower level of care setting. Respondent 3 stated,

> Well, number one is they don't have enough income, social security benefits don't increase when California cost of living is going up and up and they are still getting their $600 or $800 dollars a month and it just doesn't match. I think income is the main factor and another is if they have an addiction problem I found that you can set them up in independent living or sober living and they prefer to be homeless (Personal Communication, Participant 3, September 26, 2020).

Respondent 6 corroborated this stating,

> Money is an issue, especially for our homeless patients, if we need to try to find them placement, but they have no source of income, it makes it very difficult for us to try to get housing for them. (Personal Communication, Participant 6, September 26, 2020)

The significance of homelessness and lack of income in this study indicates that if a patient is homeless there is a higher possibility for rapid readmission back to a skilled nursing facility post discharge due to the lack of stability and resources this population faces in the community. In addition to the external barriers these clients face, many are dealing with the internal issue of co-occurring disorders. These individuals are faced with the task of transitioning back to the community after living in a stable, structured and safe environment with all their basic needs being met. The factor of homeless and lack of income proves to be challenging for these clients, and from the respondents experience one of the things they see clients that return rapidly back into a skilled facility are dealing with.

Home Health Agencies

The next factor mentioned by the respondent was a lack of services from the home health agencies that the client was referred to before discharging. The home health agencies are responsible for transitioning the client from the skilled nursing facility to where the client will be discharged to. This can include home, assisted living, transitional housing, or a room and board. Home Health Agencies (HHA) are tremendously important for the client and the family, after leaving a

medical setting like a skilled nursing facility. Home health agencies provide the client an array of services, including reminders on their medications and upcoming appointments, education regarding their diagnosis, and most importantly treatment compliance. From the perspective of the respondents, there were two common reasons that clients would rapidly return back to a skilled nursing facility when being discharged with a home health agency. The first reason was the client's lack of knowledge regarding the role of the home health agency in their post-discharge care and the second reason was the lack of follow through from the home health agencies. Participant 5 shared their experience of clients not understanding the role of the home health agency in their follow-up care.

> I think that it helps them to stay, but a lot of the time if they just don't understand the role of the home health agency they just end up going back to the hospital or the emergency room, rather than calling them to tell them they have an issue. Um a lot of the times they don't go every day or aren't seen the next day of discharge so I think that, that also poses a break in the system. (Personal Communication, Participant 5, September 20, 2020).

Participant 3 provided insight on the lack of services by home health as not very effective for client's post-discharge.

> Not very, I do not think they are very effective. I find it a lot that when these patients are returning when I talk to them and I ask about home health services they say "oh well the nurse comes in and spends two

> minutes and checks my vitals and then goes". So I don't think they're very effective. It's been my experience that home health does not spend a lot of time like they should. (Personal Communication, Participant 3, September 26, 2020).

Home health agencies play an important role in helping the client transition back to the community and staying in the community. The breakdown of home health services and rapid readmission suggests that agencies need to provide further education to the client regarding the array of services home health agencies provide. Having information regarding the importance of home health agencies could potentially affect the trajectory of the client's case, ultimately making them more successful in the community.

Room and Board

Respondents all provided information regarding client's having unsuccessful discharges when being discharged to a room and board. Room and boards are unlicensed homes where the client pays for the cost of shelter and meals. The word room and board was mentioned 16 times when asked where do clients who have a quick readmission rate get discharged to. Other places where clients were mentioned to be discharged, included home and assisted living facilities. Respondent 3 described the discharge process as a vicious cycle when mentioning clients discharging to room and boards.

> It’s a vicious cycle, they normally go to independent living and room and boards and the reason why they go there is because it’s the only thing they can afford and so as a social worker it's challenging because you really want this individual to if I could I would discharge them to an actual rehabilitation center for their addiction or I would discharge them to like an actual licensed board and care or like I don’t know somewhere where they could do classes and maintain and not have to pay so much money out of their social security but because that’s the only thing they could afford and that’s the discharge process you know (Personal Communication, Participant 3, September 26, 2020)

Room and boards were not viewed in a positive light and respondents' answers suggest that room and boards are not always the most appropriate setting to discharge a client to. However, due to the client's history with other facilities and not having enough income, it is often difficult to find another place for the client to discharge to. It can be argued that from the respondent’s answers discharging a client to a room and board facility is not ideal, and one of the factors that can lead into a client’s rapid-readmission.

Mental Health and Substance Abuse Disorder

Clients with substance abuse or mental health were also mentioned to have a high readmission back into skilled nursing facilities post-discharge. The topic of mental health and substance abuse disorder was brought up across all nine interviews. For many of the respondents one of the reasons the client

becomes unsuccessful back in the community is due to turning to alcohol or drugs once discharged. Respondent 6 provided information how the substance abuse disorder manifests as a medical emergency, bringing a client back in for treatment.

> Substance abuse, alcoholism, overdoses, those are things that bring people in frequently because their behavior changes when they are under the influence or they medically need something as a result of their drug use or alcohol use. (Personal Communication, Participant 6, September 25, 2020)

Respondents explain there are community resources for the clients with substance use disorders and mental health. However, clients are not always interested in services. Respondent 3 explained that they provide a print out of information about substance abuse classes and meetings for clients with substance use disorders, however she recalls the clients “rarely do they look at it or pay attention to it”. (Personal communication, Participant 3, September 26, 2020)

In addition to a client’s choice to continue their substance use, oftentimes a client’s family members are no longer willing to be involved in the client’s recovery making it much more difficult to find a long-term solution for the client. Respondent 6 explains that due to client's co-occurring disorders they often burn their bridges with those around them.

> Their mental health and their substance abuse, their behavior issues have kind of prevented them from having a big, strong support system behind them because they've kind of burned their bridges". (Personal Communication, Participant 6, September 25, 2020)

Due to the client having little to no resources or help, the clients are discharged to any room and board that is willing to take them, beginning the cycle of discharge to rapid re-admission. Participant three describes the cycle.

> Most of the time, it's people with substance abuse issues or mental health that permanent placement doesn't work for them. So even if we get them into a room and board, if they have a substance abuse issue, they're not going to stay in that room and board for long before they're back out on the streets. (Personal Communication, Participant 3, September 27, 2020)

The issue of substance abuse and mental health as areas that are more prevalent amongst those that rapidly readmit, suggests that this population is not being adequately served within the community. Clients are being discharged to facilities that cannot adequately meet their needs and ultimately choosing not to maintain their sobriety while in the community.

Lack of Family Support and Non-compliance with Treatment

For client's discharging back into the community, having a good support network is important. Not having adequate family support at home, results in the client not being able to remain in their home, and ultimately non-compliance with

treatment. Respondent 4 explains that for client's living alone their safety poses a risk, and will ultimately return back to the hospital to receive services.

> Someone living alone, they have repeated falls and then end back at the hospital. (Personal Communication, Participant 4, September 26, 2020)

Respondents expressed that some clients do not want to discharge from the facility, due to not having assistance at home. Respondent 3 explains that the client needs that support in order to be successful.

> I feel like the number one thing that this kind of residents need is someone there pushing them to follow through, to continue care (Personal Communication, Participant 3, September 27, 2020).

The impact not having family support has for these clients suggest that proper support helps clients be successful in the community and can help the client avoid having to return back in for services. A positive family dynamic is an important aspect for the client's overall wellbeing.

In addition to not having adequate family support, the respondents provided insight that the client's self-neglect and noncompliance with their treatment served to be another factor that results in the client returning to the hospital and skilled nursing facility. Promoting a client's self-determination is one of the fundamental ethical principles of a social workers code of ethics. However, the respondents, gave insight that when client's do not follow through with their recommended treatment plan, it proves to be detrimental to their well-being,

eventually resulting in their readmission**.** Even when respondents had placed the client in a shelter or room and board, clients were noted to leave and refused to continue paying rent to the room and board. From the respondent's experience, the non-compliant clients returned faster than those that were compliant with the treatment plan recommended upon discharge. Participant 6 provided information that a client's self-determination is often associated with their return, when they choose not to continue to take care of themselves post-discharge.

> Self-neglect is a huge issue, Same thing with our non-compliant diabetics or dialysis patients. They are contributing to their problem and we can't change what they're willing to do (Personal Communication, Participant 6, September 25, 2020).

Along with being noncompliant, clients were also reported leaving against medical advice before the order to discharge was given by the physician and a proper discharge and community referral was arranged. Respondent 5 gave insight to the prognosis of those leaving against medical advice.

> Some would leave against medical advice, and sure enough within a week or two they would be back. (Personal Communication, Participant 5, September 20, 2020)

Non-compliance and leaving against medical advice suggest that clients may have the proper resources available to them, but for various reasons are choosing not to continue with them.

This research study discovered that there are many factors that play a part in the rapid readmission of clients who discharge from skilled nursing facilities. Respondents provided insight that those suffering from homelessness and lack of income were amongst the quickest to be readmitted back in for services. This study also provided information on the impact co-occurring disorders have on the client's ability to be successful in the community**,** and the impact that being discharged to a board and care had on the client's success rate**.** Information was also gained on the importance that family support and compliance with treatment has on the client's ability to stay out of treatment, and the importance of having a comprehensive home health agency manage a client's case post-discharge.

The respondents' experiences and input proved to be valuable in understanding some of the factors that lead a client to return back into a skilled nursing facility**.** Each respondent shared their discharge process, and the challenges they face facilitating a safe discharge. The implication this research has for the field of social work is both on the micro and macro level. At the micro level, this research provides insight that client's need further assistance navigating issues such as housing. Clients also need to be continuously educated on the importance of compliance with treatment, and need to receive specialized services for their co-occurring disorder. At the macro level this study provides insight to the areas that are failing the client including, a lack of long-lasting housing options for those that have both low-income and medical needs and lack of long-term comprehensive substance abuse treatment facilities.

Limitations

The limitations of this study include, the small sample size of only nine participants, and lack of other studies available to utilize as a framework for this study. This study had a total of nine participants, seven of those participants currently work in a skilled nursing facility and two work in a hospital setting. The sample size also only included three counties, with five participants from San Bernardino, one participant from Riverside and three participants from Los Angeles County. These factors are limitations due to the studies inability to generalize to the larger population. The information gained may not represent factors experienced in other counties or skilled nursing facilities. Further studies are needed to determine if all skilled nursing facility social services staff face the same challenges as the respondents that participated in the study. The other limitation to this study was that there were limited studies to model and develop this study from, and to compare the findings to.

APPENDIX A

INTERVIEW GUIDE

Factors Effecting Rapid Readmission Back into Skilled Nursing Facilities Post-Discharge Interview Guide

Directions: Please Put an X next each section that best describes you.

Gender:

Male_____ Female_____ Other_____

Age (In Years): _____

Ethnicity:

_____American Indian or Alaska Native
_____Asian
_____Black or African American
_____Hispanic or Latino
_____Native Hawaiian or Other Pacific Islander
_____White

Education Level:

_____GED/Highschool Diploma
_____Some college
_____Associates Degree
_____Bachelor's Degree
_____Master's Degree/Doctoral Degree
_____Other: (Please Specify) _____

What is your title?

____Social Worker ____Social Services Staff ____Discharge Coordinator

Which county does your facility reside?

_____San Bernardino _____Riverside _____Los Angeles

Interview Questions

1. Please describe how a discharge takes place within your facility.

2. How many beds is within in your facility? How many social services staff/social workers do you have?

3. Please describe what barriers you face when discharging clients

4. What type of patients have you observed returning to your facility most frequently?

5. What factors do you believe contribute to this particular population of client's readmissions?

6. What resources do you provide to a patient at the time of discharge?

7. What barriers do you observe and believe client's to be facing when discharging into the community?

8. How effective do you believe agencies involved in client's cases post-discharge are in helping clients stay in the community?

9. From your experience where do clients who have a quick readmission rate get discharged to?

The following research guide was developed by researchers Angela Bonilla and Francesca Salvatierra.

APPENDIX B

INFORMED CONSENT

INFORMED CONSENT

The study in which you are asked to participate is designed to understand the factors effecting clients return to long-term medical care facilities post-discharge from the perspective of social workers. The study is being conducted by Angela Bonilla and Francesca Salvatierra, graduate students under the supervision of Dr. Thomas Davis, Professor in the School of Social Work at California State University, San Bernardino (CSUSB). The study has been approved by the Institutional Review Board at CSUSB.

PURPOSE: The purpose of the study is to understand the factors effecting client's return to long-term medical care facilities post-discharge from the perspective of social workers.

DESCRIPTION: Participants will be asked various demographics, and open-ended questions regarding their experience with clients re-admitted to a long-term care facility post-discharge.

PARTICIPATION: Your participation in the study is voluntary. You can refuse to participate in the study or discontinue your participation at any time without any consequences.

CONFIDENTIALITY: Your responses will remain confidential and data will be reported individually only.

DURATION: Participation in this study will take approx. 20 to 30 minutes.

RISKS: Although not anticipated, there may be some discomfort in answering some of the questions. You are not required to answer and can skip the question or end your participation.

BENEFITS: There will not be any direct benefits to the participants. However, findings from the study will contribute to our knowledge in this area of research.

CONTACT: If you have questions about this study, please feel free to contact Dr. Davis at (909) 537-3839

RESULTS: Results of the study can be obtained from the Pfau Library ScholarWorks database (http://scholarworks.lib.csusb.edu/) at California State University, San Bernardino after July 2021.

****

I agree to have this interview be recorded utilizing the video-conference recording feature: _____ YES _____ NO

I understand that I must be 18 years of age or older to participate in your study, have read and understand the consent document and agree to participate in your study.

_____ _____

Place an X mark here Date

.

APPENDIX C

EMAIL SOLICITATION

Dear Mr. or Ms. (Insert participants last name here)

Thank you for your interest in participating in our research project. Our names are Angela Bonilla and Francesca Salvatierra, we are both current Masters of Social Work student's at California State University, San Bernardino. The purpose of this research project is to gain perspective from social workers and social services staff on the factors they believe are affecting the rapid-readmission of clients back into skilled nursing facilities post-discharge. Participation in this research study is completely voluntary, and no identifiable information about yourself or your facility will be utilized.

Due to the current COVID-19 pandemic and the safety of yourself and the researchers. In order to participate in this study, we would like to meet with you via a private video-conferencing format such as Zoom or Google Meets . The duration of the study should take approximately 20-30 minutes. Please provide 3 days and times that work best for you. If you have any questions, please do not hesitate to contact us. Thank you for your time and consideration to participate in this study, we look forward to meeting with you.

Best,

Angela Bonilla & Francesca Salvatierra
Masters of Social Work students

APPENDIX D

IRB APPROVAL LETTER

CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO

June 13, 2020

CSUSB INSTITUTIONAL REVIEW BOARD
Administrative/Exempt Review Determination
Status: Determined Exempt
IRB-FY2020-198

Francesca Salvatierra Thomas Davis, Angela Bonilla
CSBS - Social Work
California State University, San Bernardino
5500 University Parkway
San Bernardino, California 92407

Dear Francesca Salvatierra Thomas Davis, Angela Bonilla

Your application to use human subjects, titled "Social Workers Perception of Factors effecting clients return to skilled nursing care facilities post-discharge" has been reviewed and approved by the Chair of the Institutional Review Board (IRB) of CSU, San Bernardino has determined your application meets the federal requirements for exempt status under 45 CFR 46.104. The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risk and benefits of the study to ensure the protection of human participants. The exempt determination does not replace any departmental or additional approvals which may be required.

You are required to notify the IRB of the following as mandated by the Office of Human Research Protections (OHRP) federal regulations 45 CFR 46 and CSUSB IRB policy. The forms (modification, renewal, unanticipated/adverse event, study closure) are located in the Cayuse IRB System with instructions provided on the IRB Applications, Forms, and Submission webpage. Failure to notify the IRB of the following requirements may result in disciplinary action.

- Ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.
- Submit a protocol modification (change) if any changes (no matter how minor) are proposed in your study for review and approval by the IRB before being implemented in your study.
- Notify the IRB within 5 days of any unanticipated or adverse events are experienced by subjects during your research.
- Submit a study closure through the Cayuse IRB submission system once your study has ended.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillesp@csusb.edu. Please include your application approval number IRB-FY2020-198 in all correspondence. Any complaints you receive from participants and/or others related to your research may be directed to Mr. Gillespie.

Best of luck with your research.

Sincerely,

Donna Garcia

Donna Garcia, Ph.D., IRB Chair
CSUSB Institutional Review Board

DG/MG

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